

Mandatory Enrollment into Managed Care

**OFFICIAL**

State: New Jersey

Citation	Condition or Requirement
1932 (a)(1)(A)	4. The state plan program implements mandatory enrollment into managed care on a statewide basis.
	C. <u>State Assurances and Compliance with the Statute and Regulations.</u>
	The state assures all the applicable requirements that include, but are not limited to, the following statutes and regulations are met:
1932 (a)(1)(A)(i)(I) 1903 (m); 438.50 (c)(1)	1. Section 1903 (m) of the Act, for MCOs and MCO contracts.
1932 (a)(1)(A)(i)(I) 1905 (t) 42 CFR 438.50 (c)(2) 1902 (a)(23)(A)	2. Section 1905 (t) of the Act for PCCMs and PCCM contracts.
1932 (a)(1)(A)	3. Section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to 42 CFR 438.50 (c)(3) limit freedom of choice by requiring recipients to receive their benefits through managed care entities.
1932 (a)(1)(A) 42 CFR 431.51	4. 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in Section 1905 (a)(4)(C).
1932 (a)(1)(A) 42 CFR 438	5. 42 CFR 438 for MCOs.
42 CFR 438.50 (c)(4) 1903 (m) 1932 (a)(1)(A) 42 CFR 438.6 (c) 42 CFR 438.50 (c)(6)	6. 42 CFR 438.6 (c) for payments under any risk contracts.
1932 (a)(1)(A) 42 CFR 447.362 42 CFR 438.50 (c)(6)	7. 42 CFR 447.362 for payments under any nonrisk contracts.
45 CFR 74.40	8. 45 CFR 74.40 for procurement of contracts.

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D. Eligible groups

1932 (a)(1)(A)(i)

1. List all eligible groups that will be enrolled on a mandatory basis:

The eligible groups that will be enrolled on a mandatory basis include only those individuals who are eligible under Title XIX of the Social Security Act, as follows: Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF); AFDC/TANF-Related, New Jersey Care...Special Medicaid Program for Pregnant Women and Children; SSI-Aged, Blind, Disabled and Essential Spouses; New Jersey Care...Special Medicaid Programs for Aged, Blind and Disabled; Division of Developmental Disabilities (DDD) clients, including the DDD clients receiving services under the Community Care Waiver; Medicaid Only or SSI-Related Aged, Blind and Disabled; uninsured parents/caretakers and children who are covered under NJ FamilyCare.

2. Mandatory exempt groups:

Use a check mark to indicate if the state will enroll any of the mandatory exempt groups on a voluntary basis.

1932 (a)(2)(B)  
42 CFR 438 (d)(1)

i. Recipients who are also eligible for Medicare

X The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(C)  
42 CFR 438 (d)(2)

ii. Indians who are members of Federally recognized Tribes except: when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

X The state will allow these individuals to voluntarily enroll in the managed care program.

1932 (a)(2)(A)(i)  
42 CFR 438.50 (d)(3)(i)

iii. Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

X The state will allow these individuals to voluntarily enroll in the managed care program.

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1932 (a)(2)(A)(iii) 42 CFR 438.50 (d)(3)(ii)	iv. Children under the age of 19 years who are eligible under 1902(e)(3) of the Act. <u>X</u> The state will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(v) 42 CFR 438.50 (3)(iii)	v. Children under the age of 19 years who are in foster care or other out-of-the-home placement. <u>X</u> The state will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(iv) 42 CFR 438.50 (3)(iv)	vi. Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E. <u>X</u> The state will allow these individuals to voluntarily enroll in the managed care program.
1932 (a)(2)(A)(ii) 42 CFR 438.50 (3)(v)	vii. Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs. <u>X</u> The state will allow these individuals to voluntarily enroll in the managed care program.

E. **Identification of Mandatory Exempt Groups**

- |                                  |  |
|----------------------------------|--|
| 1932 (a)(2)<br>42 CFR 438.50 (d) | 1. The state defines children who receive services that are funded under section 501(a)(1)(D) of title V as children under 19 years of age who are receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V, that is, children who have birth defects, chronic disorders, developmental delay, or who may be at risk for developmental disabilities. These children are identified through the SSI file. |
| 1932 (a)(2)<br>42 CFR 438.50 (d) | 2. The state's definition of these children is in terms of both program participation and special health care needs.   |
| 1932 (a)(2)<br>42 CFR 438.50 (d) | 3. The scope of these title V services includes services received through a family-centered, community-based, coordinated care system.   |

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1932(a)(2) 42 CFR 438.50 (d)	<p>4. The state identifies the following groups of children who are exempt from mandatory enrollment by comparison with the SSI files:</p> <ol style="list-style-type: none"><li>Children under 19 years of age who are eligible for SSI under title XVI;</li><li>Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; (DDD/CCW)</li><li>Children under 19 years of age who are in foster care or other out-of-home placement;</li><li>Children under 19 years of age who are receiving foster care or adoption assistance.</li></ol>
1932(a)(2) 42 CFR 438.50 (d)	<p>5. The state allows both children and adult recipients to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. Recipients may be temporarily exempted from participation if they:</p> <ol style="list-style-type: none"><li>are pregnant women, beyond the first trimester, who have an established relationship with an obstetrician;</li><li>have a terminal illness and have an established relationship with a physician; have a chronic, debilitating illness and have received treatment from a physician or a team of providers with whom they have an established relationship;</li><li>do not speak English or Spanish and have an illness requiring on-going treatment and have an established relationship with a physician who speaks the same language and there is no available primary care physician in any of the participating managed care plans who speaks the patient's language; or</li><li>have no choice of at least two PCPs within 30 miles of their residence.</li></ol>
1932 (a)(2) 42 CFR 438.50 (d)	<p>6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care:</p> <ol style="list-style-type: none"><li>Recipients who are also eligible for Medicare: Self-identification and showing of a Medicare card.</li></ol>

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- ii.                      Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act:

Self-identification and showing of a Federally-recognized tribal membership card.

42 CFR 438.50

- F.                      List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment: \

42 CFR 438.50

- G.                      Other eligible groups that will be permitted to enroll on a voluntary basis:
1. Children under 19 years of age who are eligible for SSI under Title XIX. This includes special needs children, i.e., children who have complex/chronic medical conditions, including physical and developmental disabilities.
  2. Children under 19 years of age who are described in section 1902(e)(3) of the Social Security Act.
  3. Children under 19 years of age who are receiving foster care or adoption assistance who the State is otherwise covering who are eligible under the Title XIX State Plan.
  4. Children under 19 years of age who are receiving services through a family-centered, community-based, coordinated care system receiving grant funds under section 501(a)(1)(D) of Title V, that is, children who have birth defects, chronic disorders, developmental delay, or who may be at risk for developmental disabilities.
  5. Dual Medicare-Medicaid eligibles.
  6. Indians who are members of Federally-recognized tribes.

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H. Enrollment process.

1932 (a)(4)  
42 CFR 438.50

1. Definitions:

- i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.
- ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.

1932 (a)(4)

2. The State process for enrollment by default will preserve:

- i. the existing provider-recipient relationship (by allowing enrollee disenrollment and re-enrollment upon request of the enrollee);
- ii. the relationship with providers that have traditionally served Medicaid recipients; and
- iii. the equitable distribution of Medicaid recipients among qualified MCOs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702 (a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2).

1932 (a)(4)  
42 CFR 438.50

3. The state's default enrollment process includes:

- i. Lock-in for one year for managed care for TANF and TANF-related populations subject to the provisions regarding beneficiary choice.

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- ii. A 60-day time frame for recipients to choose a health plan before being auto-assigned.
- iii. Notification of the recipient's tentative assignment by letter, with the initial enrollment package, within 7 days of the determination of eligibility. The enrollment package includes information regarding each MCO, including the MCO to which the recipient has tentatively been assigned. Three outreach efforts are made (mail, appointment and final reminder), and if an MCO is not chosen by the recipient, a card is issued which includes the MCO's name and telephone number.
- iv. The state notifies the recipient who is auto-assigned of the right to disenroll without cause during the first 90 days of their enrollment. Notification occurs at the same time the recipient is notified of enrollment.
- v. The default assignment algorithm used for auto-assignment is a random assignment to any one of the contracted MCOs.
- vi. The state monitors changes in the rate of default assignment by a review of the reasons for transfer to another MCO, the reasons presented in the grievance process and outreach efforts.

1932 (a)(4)  
42 CFR 438.50

I. State assurances on the enrollment process

- 1. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO does not have capacity to accept all who are seeking enrollment under the program.
- 2. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in an MCO will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52 (b)(3).

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\_\_\_\_\_ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52 (a) for MCOs and PCCMs. (If applicable, place check mark to indicate state's affirmation.)

3. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932 (a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

X The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56 (g) if recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

1932 (a)(4)  
42 CFR 438.50

J. Disenrollment

1. The state allows lock-in for managed care for a period of 12 months in the case of TANF and TANF-related recipients.
2. The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56 (c).
3. The State allows an enrollee to disenroll during the remainder of any period of enrollment following the first three months, if the MCO approves the enrollee's request to disenroll, or: if the enrollee requests in writing to the State and the MCO, for good cause; the request cites the reasons why the enrollee wishes to disenroll, such as poor quality of care, lack of access to specialty services, or other reasons satisfactory to the State; the MCO provides information that the State may require, and the State determines that good cause for disenrollment exists.
4. In addition to circumstances permitted under 42 CFR 438.56(c), an enrollee may request disenrollment from an MCO when the enrollee has substantially more convenient access to a primary care physician who participates in another MCO; or has been granted an exemption from mandatory managed care.

K. INFORMATION REQUIREMENTS FOR BENEFICIARIES

1932 (a)(5)  
42 CFR 438.50  
42 CFR 438.10

The State assures that its state plan program is in compliance with 42 CFR 438.10 (i) for information requirements specific to MCO programs operated under section 1932 (a)(1)(A)(i) state plan amendments.

1932 (a)(5)(D)

L. Description of excluded services for MCOs

The State assures that recipients receive all Medicaid benefits through managed care organizations, except that the following are available to managed care beneficiaries through fee-for-service:

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1. Personal Care Assistant Services
2. Medical Day Care
3. Outpatient Rehab – Physical therapy, occupational therapy, and speech pathology services
4. Abortions and related services
5. Transportation – lower mode
6. Sex Abuse Examinations
7. Services Provided by New Jersey MH/SA and DYFS Residential Treatment Facilities or Group Homes.
8. Family Planning Services and Supplies when furnished by a nonparticipating provider.
9. Home health agency services for the non-dually eligible aged, blind, disabled (ABD) population.
10. Prescription drugs (legend and non-legend covered by the Medicaid program) for the non-dually eligible ABD population.
11. Mental Health Services for enrollees who are not clients of the Division of Developmental Disabilities.
12. Substance Abuse Services—diagnosis, treatment, and detoxification for enrollees who are not clients of the Division of Developmental Disabilities
13. Costs for Methadone and its administration
14. Drugs.
  - a. Atypical antipsychotic drugs within the Specific Therapeutic Drug Classes H7T and H7X and generic equivalents
  - b. Methadone – cost and its administration.
15. Up to twelve (12) inpatient hospital days when required for social necessity, in accordance with Medicaid regulations.
16. DDD/CCW waiver services: individual supports (which includes personal care and training), habilitation, case management, respite, and Personal Emergency Response Systems (PERS).
17. Nursing Facility care
18. Inpatient psychiatric services (except for RTCs) for individuals under age 21 and 65 and over
19. Intermediate Care Facility/Mental Retardation Services
20. Waiver (except Division of Developmental Disabilities Community Care Waiver) and demonstration program services.

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Sanctions for MCOs and PCCMs

1932(e)

42 CFR 428.726

- X (a) The State monitors for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in the manner specified below:

The State will require the MCO to permit the Department and the United States Department of Health and Human Services or its agents to have the right to inspect, audit or otherwise evaluate the quality, appropriateness and timeliness of services performed under this contract, including through a medical audit. For all deficiencies found by the State and/or the ERO, the MCO must submit a plan of action to correct, evaluate, respond to, resolve, and follow up on any identified problems. Failure to resolve or correct the deficiency may result in sanctions including those, at a minimum, described in 42 CFR 438 Subpart I. Specific details for each type of violation and corresponding sanction are stipulated in the MCO contract.

- X (b) The State uses the definition below of the threshold that must be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Imposition of temporary management would occur when the State finds the MCO has been sanctioned three or more consecutive times for violations described at 42 CFR 438.700 or fails to attain and maintain financial stability in accordance with the fiscal requirements set forth by the New Jersey Department of Banking and Insurance.

- X (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

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